Applied Assessments LLC

An Independent Review Organization

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Notice of Independent Review Decision

Case Number:

Date of Notice: 05/04/2015

Review Outcome:

A description of the qualifications for each physician or other health care provider who reviewed the decision:

Orthopedic Surgery

Description of the service or services in dispute:

Left shoulder arthroscopy with lysis of adhension and manipluation

Upon Independent review, the reviewer finds that the previous adverse determination / adverse determinations should be:

- ☑ Upheld (Agree)
- ☐ Overturned (Disagree)
- ☐ Partially Overturned (Agree in part / Disagree in part)

Patient Clinical History (Summary)

The patient is a male with complaints of left shoulder pain. On 05/07/14, MRI of the left shoulder revealed moderate strain of the distal supraspinatus tendon without full thickness rotator cuff tear. There was also post-traumatic biceps tendinitis versus normal communication of the tendon sheath with no joint effusion. The acromion was type I without significant hypertrophy. There were small cystic changes seen within the humeral head with largest measuring 4mm. On 02/11/15, the patient was seen in clinic. He stated he hurt his left shoulder on xx after falling off a truck and landing on left side of his shoulder. He also had a left elbow dislocation but most of his problems were with motion of his shoulder. He had cortisone injection in 08/14 and underwent intensive therapy and work hardening program but continued problems getting motion. He was taking ibuprofen for pain. On exam, active and passive elevation was limited to 120 degrees, abduction to 100, external rotation to 60, and internal rotation to the sacrum. He had 4/5 strength in supraspinatus and external rotators and sensation was intact. Noting he failed all conservative measures, surgery was recommended.

Analysis and Explanation of the Decision include Clinical Basis, Findings and Conclusions used to support the decision.

On 02/25/15, a utilization review non-certified the requested procedure. It was noted there was little information regarding failure of PT and or injections, and it was noted it was unclear as to what current attempts at therapy there had been. It was also noted this type of surgical procedure was under study as most patients did get better with continued conservative care. On 03/31/15, utilization review noted the request for left shoulder arthroscopy with lysis of adhesions and manipulation under anesthesia was not medically necessary, as the patient exhibited greater than 90 degrees of abduction on exam. Recommendation was for non-certification.

Guidelines indicate there should be documented failure of conservative care of at least three to six months and range of motion should remain significantly reduced less than 90 degrees for abduction. Guidelines

indicate this type of surgery is currently under study and that most cases should resolve with continued conservative care. For this patient, while the records indicate the patient had undergone conservative care, there is paucity of clinical information regarding current care to support the request, and records indicate that the most recent exam fails to document objectively the range of motion of the left shoulder. Therefore, it is the opinion of this reviewer that the request for left shoulder arthroscopy with lysis of adhesions and manipulation is not medically necessary and prior denials are upheld.

A description and the source of the screening criteria or other clinical basis used to make the decision:

- ☐ ACOEM-America College of Occupational and Environmental Medicine um
- ☐ knowledgebase AHCPR-Agency for Healthcare Research and Quality Guidelines
- ☐ DWC-Division of Workers Compensation Policies and
- ☐ Guidelines European Guidelines for Management of Chronic
- ☐ Low Back Pain Interqual Criteria
- ☑ Medical Judgment, Clinical Experience, and expertise in accordance with accepted medical
- ☐ standards Mercy Center Consensus Conference Guidelines
- ☐ Milliman Care Guidelines
- ☑ ODG-Official Disability Guidelines and Treatment
- ☐ Guidelines Pressley Reed, the Medical Disability Advisor
- ☐ Texas Guidelines for Chiropractic Quality Assurance and Practice Parameters
- ☐ Texas TACADA Guidelines
- ☐ TMF Screening Criteria Manual
- ☐ Peer Reviewed Nationally Accepted Médical **Literature** (Provide a description)
- ☐ Other evidence based, scientifically valid, outcome focused guidelines (Provide a description)